General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 1 Dingle Road, Upholland, SKELMERSDALE, Lancashire, WN8 0EN

Pharmacy reference: 1033932

Type of pharmacy: Community

Date of inspection: 14/05/2019

Pharmacy context

This is a community pharmacy found on a major route between Wigan and Skelmersdale. It is situated in the village centre of Upholland, near Skelmersdale. The pharmacy dispenses NHS prescriptions, private prescriptions, sells over the counter medicines and provides seasonal flu vaccinations. A number of people receive their medicines inside multi-compartment compliance aids.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team follows written procedures to help make sure the pharmacy provides services safely and effectively. Members of the team records things that go wrong, but they do not review the records, so they may miss some learning opportunities. And there may be a risk of similar mistakes happening again. The pharmacy generally keeps the records it needed to by law. People who work in the pharmacy are given training about the safe handling and storage of data. This helps to make sure that they know how to keep private information safe.

Inspector's evidence

There was a set of standard operating procedures (SOPs), some of which had not been reviewed since March 2015. These had been updated by the company, but the pharmacy team said they had not read the updated version. So current practice may not always reflect the current SOPs.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). A recent error involved a picking error between atenolol 100mg and allopurinol 100mg tablets. The pharmacy team investigated the error and actions were taken to help reduce the risk of a similar mistake e.g. segregating the dispensary location of these tablets.

Members of the pharmacy team recorded their near miss errors on a paper log. But there was no review of the records to identify trends or underlying factors. Staff could not provide any examples of things they had done following near misses to help prevent similar mistakes.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The trainee dispenser was able to describe what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore a standard uniform and had badges identifying their name and role. The responsible pharmacist (RP) had their notice displayed prominently.

The pharmacy had a complaints procedure and a notice on display in the retail area advised customers how they could raise concerns with the pharmacy team or with the company's head office. Any complaints would be recorded and sent to the head office to be followed up.

A current certificate of professional indemnity insurance was on display in the pharmacy. Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order.

Controlled drugs (CDs) registers were appropriately maintained, with running balances recorded and checked monthly. The balance of three random CDs were checked and found to be accurate.

An information governance (IG) policy was available. The pharmacy team received annual IG training and had signed confidentiality agreements in their contracts. When questioned, the trainee technician was able to correctly identify what information was confidential waste and how it was segregated and destroyed using an on-site shredder. A leaflet provided information about how the company handled

and stored people's information.

Safeguarding procedures were available. The pharmacy team had safeguarding training and the pharmacist said he had completed level 2 safeguarding training. Contact details of the local safeguarding board were available in the pharmacy. The trainee technician said

Principle 2 - Staffing ✔ Standards met

Summary findings

There are normally enough staff to manage the pharmacy's workload. But members of the team sometimes struggle to cope when they have to cover holidays or leave. This means they are not always up to date with their work, which puts them under pressure. Members the pharmacy team complete learning modules to help them keep their knowledge up to date.

Inspector's evidence

At the time of inspection there had been an electrical fault which meant the pharmacy could not process prescriptions. To manage the situation the pharmacy staff were turning non-urgent prescriptions away or asking people to return later that day.

The pharmacy team included a trainee technician, and two dispensers – one of whom was in training. The pharmacy team were adequately trained or in accredited training programmes.

The normal staffing level was a pharmacist and three members of staff. The pharmacist manager and a dispenser had left the business in March 2019. The staff said since their departure, they had struggled with the workload because the normal staffing level was not always maintained.

They said staff leave was not always well managed which meant the pharmacy often had to operate with fewer staff than it was supposed to have. There was a staggered holiday system in place and relief staff could be requested, but they were not always provided. The staff said on some occasions they had fallen behind with the workload by up to seven days, but said they were currently up to date.

A new dispenser had commenced employment on the day of inspection. She was currently limited in her role and was shadowing other staff until training in the pharmacy processes was provided.

The trainee dispenser said she was able to ask the trainee technician for help with her dispensing course. But she had fallen behind because a number of her training modules had not been signed off.

The company provided the pharmacy team with a structured e-learning training programme. And the training topics appeared relevant to the services provided and those completing the e-Learning. Staff were allowed learning time to complete training, training records were kept, and staff said everyone was up to date.

The trainee dispenser gave an example of how she would sell a pharmacy only cough medicine using the WWHAM questioning technique, refuse co-codamol sales she felt were inappropriate and refer to the pharmacist if needed.

The locum pharmacist said he felt able to exercise his professional judgment and this was respected by the pharmacy team. Appraisals had been conducted by the previous pharmacy manager. The pharmacy team said they were up to date in their appraisals. They were asked to complete a pre-appraisal form to discuss their performance, training requirements and areas for improvement. They felt that the

appraisal process was a good chance to discuss their work.

Staff were aware of the whistleblowing policy in place and staff said that they would be comfortable to escalate any concerns to the head office. The locum pharmacist said he was not set any service-based targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are generally suitable for the services provided. But it is untidy, which spoils the professional appearance.

Inspector's evidence

The pharmacy appeared cluttered, and litter had accumulated on the floor. A cleaning rota was on display, but staff said they had fallen behind with this due to the workload.

The size of the dispensary was sufficient for the workload. A sink and washing facilities were available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary and access was restricted by the position of the counter. Part of the counter area was screened to help maintain privacy of conversations.

The temperature was controlled in the pharmacy by the use of a thermostatic air conditioning units in both the retail and dispensary areas. Lighting was sufficient. The staff had access to a kettle, microwave, separate staff fridge, and WC facilities.

A consultation room was available with access restricted by use of a lock. The space was clutter free with a computer, desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services and they are easy to access. The pharmacy's working practices are generally safe. It gets its medicines from reputable sources, stores them appropriately and carries out some checks to help make sure that they are in good condition.

Inspector's evidence

The pharmacy entrance was via a ramp to a single door and allowed wheelchair access. Pharmacy practice leaflets gave information about the services offered. There was also information available on the company's website. Pharmacy staff were able to list and explain the services provided by the pharmacy. The pharmacy opening hours were displayed at the entrance and a range of leaflets provided information about various healthcare topics.

Dispensed by and checked by boxes were initialled on dispensing labels to provide an audit trail. Dispensing baskets were used for segregating individual patient prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using an alphabetical retrieval system. Prescriptions were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out.

Schedule 3 CDs stored on collection shelves were highlighted to indicate their presence so that staff could check prescription validity at the time of supply. However; schedule 4 CDs were not. So there is a risk that these medicines could be supplied after the prescription had expired.

High risk medicines (such as warfarin, lithium and methotrexate) were not regularly highlighted. So the pharmacy team may not be aware when they are being handed out in order to check that the supply is suitable for the patient.

The staff were aware of the risks associated with the use of valproate during pregnancy and these medicines had been segregated onto their own shelf. The pharmacy team could not find the educational material to hand out when the medicines were supplied. So people may not be provided with all of the appropriate information. The pharmacy team said they were not aware of any current patients who met the risk criteria.

Some medicines were dispensed off-site at the company's NuPAC automated dispensing hub pharmacy. These prescriptions were clinically checked by the pharmacist the first time they were dispensed and then every six months; or if there was a change in medication or circumstances. Otherwise repeat prescriptions were not normally clinically checked, which means there may be a risk that some important information could be overlooked. Prescriptions were labelled on the PMR system, and the information was transmitted to the hub. A cover sheet containing the patient details was also

transmitted alongside a patient profile sheet with details of their medicines. The hub used an automated robot to dispense the medicines into pouches on a roll. Each pouch contained the medicines to be taken at specific dosage time (e.g. at breakfast), and the roll was in time and date order.

When the pharmacy began sending prescriptions to the hub the information they sent was validated by a team in the head office to ensure it was accurate before dispensing. This carried on until the pharmacist at the branch was 'accredited' by reviewing 125 submissions without making any errors. Once the pharmacist was 'accredited' they were able to send the information directly to the dispensing robot at the hub. If an error was made the process was reset so that head office would review the submissions until the pharmacist had reviewed a further 125 without error. The dispensed medicines were returned to the pharmacy labelled with patient information, their location of dispensing and a security seal. Patient information leaflets (PILs) were supplied with the medicines.

A repeat prescription service was offered where patients would contact the pharmacy to order their medication. A record of requested medication was kept, and any missing items were queried with the GP surgery.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a delivery book was used to obtain patient signatures on receipt of the medication. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a special's manufacturer.

The pharmacy was not yet compliant with the Falsified Medicines Directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine safety checks of medicines.

Stock was date checked on a three month rotating cycle, but it had not been completed since January 2019. A date checking matrix was signed by staff and shelving was cleaned as part of the process. Short dated stock was highlighted using a sticker. A spot check of medicines found most medicines in date, A bottle of procyclidine 5mg tablets was found expired. Liquid medication did not always have the date of opening written on, including a bottle of morphine sulphate oral solution which expired three months after opening. So staff may not be aware if the medicine remains suitable for dispensing.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock.

There was a clean medicines fridge, fitted with a thermometer. The minimum and maximum temperature was being recorded daily and records showed they had been in range for the last three months.

Patient returned medication was segregated from current stock in designated bins for storing waste medicines located away from the dispensary.

Drug alerts were received electronically. Alerts were printed, action taken was written on, initialled and signed before being filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has access to the equipment they need for the services they provide.

Inspector's evidence

The staff had access to the internet for general information. This included access to medicine information on the BNF, BNFc and drug tariff resources. All electrical equipment appeared to be in working order. According to the stickers attached, all electrical equipment had been PAT tested in April 2020.

There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy.

The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.